

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07386

CERTIFICATE OF DEATH

Reg. Dist. No.

07377
100

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA				c. LENGTH OF STAY IN 1b 4 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSPITAL				d. STREET ADDRESS CHAPTICO (RURAL)			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last THORNTON KINSEY BRIDGETT				4. DATE OF DEATH Month Day Year JULY 7 1957			
5. SEX MALE	6. COLOR OR RACE W-US	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1903	9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME HAMMOND BRIDGETT				14. MOTHER'S MAIDEN NAME MATTIE ST. CLAIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-22-0935		17. INFORMANT Address MRS. THORNTON BRIDGETT, CHAPTICO, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO Interval between onset and death 3 MONTHS							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
				20f. (City or town) _____		(County) _____ (State) _____	
21. I certify that I attended the deceased from JANUARY, 1952 to JULY 7, 1957 , that I last saw the deceased alive on JULY 7, 1957 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John H. Giffen				P ADDRESS (Street, city or town, state) Negreesville, Md.			
DATE SIGNED 7/7/57							
PHYSICIAN'S NAME (Type) Crehart Inc. La Plata Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-10-57		22c. NAME OF CEMETERY OR CREMATORY Dentsville Mc.		22d. LOCATION (City, town, or county) (State) Dentsville Md	
23. FUNERAL DIRECTOR'S SIGNATURE Crehart Inc. La Plata Md.				ADDRESS La Plata Md.		24a. REC'D BY REGISTRAR DATE 7/9/57	
				24b. REGISTRAR'S SIGNATURE Julia H. Rose			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. 1000, 1960

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. MEDICAL HISTORY		11. PRESENT ILLNESS		12. POSTMORTEM EXAMINATION	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN	
19. SIGNATURE OF BURIAL OFFICIAL		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CHURCH	
22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERMENT		24. SIGNATURE OF CREMATION	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

BUREAU V. S.

JUL 11 1967

RECEIVED

07387

CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY C. CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Dentsville		c. LENGTH OF STAY IN 1b Life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) CLARENCE First A. Middle COOKSEY Last		4. DATE OF DEATH JULY 12 1957 Month July Day 12 Year 1957	
5. SEX Male	6. COLOR OR RACE US-W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 17 1899 9. AGE (In years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Matthais A. Cooksey		14. MOTHER'S MAIDEN NAME Sarah E. Hancock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -	17. INFORMANT Ernest Cooksey Address Dentsville Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure. 900.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident. DUE TO (c) Generalized arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH 5 min. 5 hrs. 10 years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) He fell off of back step and hit his head.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) He fell off of back step of his home.	
20c. TIME OF INJURY Month, Day, Year 8:20 a.m. July 11 1957	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) (County) (State) Dentsville. Char. Md.
21. I certify that I attended the deceased from May 1947 to 12 July 1957 , that I last saw the deceased alive on 12 July 1957 , and that death occurred at 12:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE A. Wooddy		ADDRESS (Street, city or town, state) La Plata. Md.	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODDY		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 7-15-57	22c. NAME OF CEMETERY OR CREMATORY DENTSVILLE CEM.	22d. LOCATION (City, town, or county) (State) DENTSVILLE Md.
23. FUNERAL DIRECTOR'S SIGNATURE HUNT FUNERAL HOME		ADDRESS WALDORF Md.	24a. RECEIVED BY REGISTRAR JUL 16 1957
		24b. REGISTRAR'S SIGNATURE Calvin P...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HANCOCK		65		M		W		1892		BOSTON		MASSACHUSETTS		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA	
JULY 16, 1957		BOSTON		HEART DISEASE		NATURAL		10 DAYS		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF CHURCH CLERK		SIGNATURE OF BURIAL CLERK	
J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK		J. H. HANCOCK	

BUREAU V. S.

JUL 16 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07380

07388

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Welcome (Rural)</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Welcome (Rural)</u> TOWN STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Katie Adella Golden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>July 25 1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct. 2 1888</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>C. Andrew Mills</u>				14. MOTHER'S MAIDEN NAME <u>Katie Keiffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>William C. Golden, Welcome Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 170X IMMEDIATE CAUSE (A) <u>Metastatic cancer</u> ANTECEDENT CAUSE(S) DUE TO <u>site undetermined</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Breast Cancer of bone mpts (either one)</u> (C) <u>Cardiac insufficiency</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 year</u> <u>1 year</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Breast Cancer</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-22</u> , 19 <u>57</u> , to <u>7-25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-24</u> , 19 <u>57</u> , and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>La Plata Md</u>		DATE SIGNED <u>7-26-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>July 28 1957</u>		NAME OF CEMETERY OR CREMATORY <u>Chicamuxen M.E. Chicamuxen Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>[Signature]</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Huntt Funeral Home Waldorf, Md.</u>	

JUL 30 1957

CERTIFICATE OF DEATH

Reg. Dist. No. 100

(7389)

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2401 Southern Ace. S. E. Wash, D. C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hospital</u>				d. STREET ADDRESS <u>16X2.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jean</u> Middle <u>Marie</u> Last <u>Gonzales</u>				4. DATE OF DEATH Month <u>July</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12/1957</u>	9. AGE (In years last birthday) yrs. <u>8</u>	IF UNDER 1 YEAR Months <u>8</u>	IF UNDER 24 HRS. Days <u>8</u> Hours <u>8</u> Min. <u>8</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charles County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Alfred A. Gonzales</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Jean Cassell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT Address <u>mother 2401 Southern Ave. Wash, D. C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>762.5</u> DUE TO <u>Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Prematurity (30 wks)</u> DUE TO (b) <u>Dist 3# 6 oz</u> DUE TO (c) <u>Dist 3# 6 oz</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7-12-57</u> <u>7-12-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-12-57</u> , 19 <u>57</u> , to <u>7-12-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>7-12-57</u> , 19 <u>57</u> , and that death occurred at <u>4:17 p.m.</u> , from the causes and on the date stated above. ADDRESS (street, city or town, state) <u>La Plata, Md.</u>							
ACTUAL SIGNATURE <u>E. J. Edelen</u>				M.D. <u>La Plata, Md.</u>		DATE SIGNED <u>7-12-57</u>	
PHYSICIAN'S NAME (Type) <u>E. J. EDELEN</u>				E. J. Edelen, M. D., La Plata, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>7-15-57</u>		<u>Secord Heart La Plata</u>		<u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard Mc La Plata</u>				ADDRESS <u>La Plata, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>7/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18. BROMITIA-HIAH TO TYNTRAPZ STATE OF MARYLAND

BUREAU V. 3.

JUL 22 1957

RECEIVED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07382

07390

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>ST. MARY'S</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>HUGHESVILLE</u>		<u>VISITING (2 wks)</u>		TOWN <u>MECHANICSVILLE</u>		<u>18X02</u>	
HOSPITAL OR STREET ADDRESS <u>Rt. #5 north of village</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>MAUDE</u> (Last) <u>JARBOE</u>				(Month) <u>JULY</u> (Day) <u>23</u> (Year) <u>1957</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>FEMALE</u>	<u>W-US.</u>	<u>SINGLE</u>	<u>SEPT. 3-1885</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>TEACHER (RETIRED)</u>		<u>TEACHING</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Raphael S. Jarboe</u>				<u>Ella L. Stewart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>—</u>		<u>MRS. Fobes Bowling - Waldorf Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE, ACUTE</u>						<u>15 MINUTES</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>ESSENTIAL HYPERTENSION</u>						<u>10 YEARS</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>—</u>		<u>—</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<u>—</u>		<u>—</u>		<u>—</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>—</u>			
<u>—</u>		<u>—</u>		<u>—</u>			
22. I hereby certify that I attended the deceased from <u>JULY 1947</u> , to <u>JULY 23, 1957</u> , that I last saw the deceased alive on <u>JULY 23, 1957</u> , and that death occurred at <u>10:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John H. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville, Md.</u>			
				DATE SIGNED <u>7/23/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>7-26-57</u>		<u>ST. Joseph Cem</u>		<u>MORGANZA, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>—</u>		<u>—</u>		<u>P. B. Robinson - Leonardtown Md.</u>		<u>—</u>	
DATE <u>7/26/57</u>							

RECEIVED

JUL 29 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND AND STATE OF MARYLAND OF HEALTH-BALTIMORE 18

2000-2000

1. Name of deceased: [illegible]
2. Date of death: [illegible]
3. Place of death: [illegible]
4. Cause of death: [illegible]
5. Manner of death: [illegible]
6. Signature of physician: [illegible]
7. Signature of registrar: [illegible]
8. Date of registration: [illegible]

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07383

07391

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Harlee</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>La Plata</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>La Plata</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>George A. HANSON</i>		<i>7 20 1957</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Male</i>	<i>col</i>	<i>married</i>	<i>Feb 10, 1891</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday yrs.
<i>farmer</i>		<i>farmer</i>	<i>66</i>
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Maryland</i>		<i>U.S.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Philip Johnson</i>		<i>Nellie Stone</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
<i>no</i>		<i>no</i>	<i>Julia Johnson La Plata, Md</i>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION
159X IMMEDIATE CAUSE (A)			INTERVAL BETWEEN ONSET AND DEATH
<i>Gastro-intestinal Cancer</i>			<i>1 year</i>
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<i>444X Hypertension</i>			<i>10 years</i>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from July 19, 1957, to 7-20, 1957, that I last saw the deceased alive on July 1, 1957, and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
SIGNATURE <i>Julia Johnson</i>		DATE SIGNED <i>7-21-57</i>	
		ADDRESS (Street, city, town, state) <i>La Plata Md</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>July 24, 1957</i>	<i>Sacred Heart</i>	<i>La Plata Md</i>
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
<i>JUL 26 1957</i>	<i>Julia Posey</i>	<i>Heart Funeral Home</i>	<i>La Plata Md</i>

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07392

CERTIFICATE OF DEATH

07385
106

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>WESLEY</u> Last <u>KEY</u>		4. DATE OF DEATH Month <u>July</u> Day <u>1</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 11, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Key</u>		14. MOTHER'S MAIDEN NAME <u>Victoria King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>J. Wesley Key Jr.</u>		Address <u>Bryans Road Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Ht. Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify, that I attended the deceased from <u>June 23, 1957</u> to <u>July 1, 1957</u> , that I last saw the deceased alive on <u>July 1, 1957</u> , and that death occurred at <u>2:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Todd</u> M.D.		ADDRESS (Street, city or town, state) <u>770 Col. Rd., N.W. Wash., D.C.</u>	
DATE SIGNED <u>July 1, 1957</u>			
PHYSICIAN'S NAME (Type) <u>John G. Todd M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>7-4-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Metropolitan Meth</u>	22d. LOCATION (City, town, or county) (State) <u>Comankey Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barney Matthews</u>		ADDRESS <u>614 4th St. S.W. Wash., D.C.</u>	
24a. REC'D BY REGISTRAR <u>7/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Chase</u>	

W. A. OVERMAN

1957 3

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The attending physician may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07386

CERTIFICATE OF DEATH

Reg. Dist. No. 14

1. PLACE OF DEATH COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Indian Head		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Charles CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rison STREET ADDRESS None (If rural give location)	
3. NAME OF DECEASED (Type or Print) Lucian Wilson KING		4. DATE OF DEATH (Month) July (Day) 13 (Year) 1957	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 8-15-26
9. AGE last birthday 30 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffer		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Rison, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James E. KING		14. MOTHER'S MAIDEN NAME Mary Monroe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219 16 0864	
17. INFORMANT & ADDRESS Wife - Rison, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary Occlusion ANTECEDENT CAUSE(S) DUE TO (B) Coronary Artery Disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 min	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION 4-5-50		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19.....; and that death occurred at..... M from the causes and on the date stated above. SIGNATURE Joseph A. Murgalo M.D. ADDRESS (Street, city, town, state) Joseph A. Murgalo, LT MC USNR DATE SIGNED 7-13-57			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 7-16-57	
NAME OF CEMETERY OR CREMATORY Pleasant Grove		LOCATION (City, town, or county) (State) Maryland	
24. REC'D BY REGISTRAR DATE 7/14/57		REGISTRAR'S SIGNATURE Mary Southland	
25. FUNERAL DIRECTOR'S SIGNATURE JOHNSON & JENKINS		ADDRESS WASH. D.C.	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

County

State

City

Age

Indian Head

Deceased, Naval Center
Yachting, Indian Head, Md.

Indian

Indian

1950

Male

Male

1950

State, Maryland

State, Maryland

Gender

Male

1950

Male - Indian, Maryland

Gender, Male

Gender, Male

Gender, Male

BUREAU V. 8

JUL 18 1957

RECEIVED

Death on Arrival

Joseph A. Murphy

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07387

CERTIFICATE OF DEATH

07394

Item 7 Film G217 7-15-57 et

Reg. Dist. No. 100

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lafayette</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woods</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pres. M. Hosp.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Minnie</u>				PALMER		4. DATE OF DEATH <u>7 5 57</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>10-14-98</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE last birthday <u>58</u> yrs.		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Richard Smith</u>				14. MOTHER'S MAIDEN NAME <u>Charity Lovell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Richard Smith Woods Rd</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7-5-57</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Cerebral Vascular Disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-20-57</u> , to <u>7-5-57</u> , that I last saw the deceased alive on <u>7-1-57</u> , 19 <u>57</u> , and that death occurred at <u>3:40</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>7-5-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>7-6-57</u>		NAME OF CEMETERY OR CREMATORY <u>Louisville</u>		LOCATION (City, town, or county) <u>Louisville Ky</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Jessie H. Parry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS	
DATE <u>7/9/57</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

BUREAU V. S.

JUL 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07388

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>Joseph</u> Last <u>Petta</u>		4. DATE OF DEATH Month <u>July</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-20-08</u> 9. AGE (In years, last birthday) <u>48</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N.P.F.</u>			
11. BIRTHPLACE (State or foreign country) <u>New York.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Dominic Petta.</u>		14. MOTHER'S MAIDEN NAME <u>Rosario Avicchio Auricchio</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>II</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Pasquale Petta.</u> Address <u>1524 Sigmund St Falls Church, VA.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fracture skull with</u> <u>9/2.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>massive crushing force</u> (c) <u>massive crushing force</u> DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>While working electric "fork lift" which slipped off its support.</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>8:55</u> a. m. <u>7/24</u> 19 <u>57</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>		20f. (City or town) <u>Indian Head</u> (County) <u>Charles</u> (State) <u>MD.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Frank G. Susan</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank A. Susan M.D. Acting</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>7-26-57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>HUNT FUNERAL HOME</u>		22d. LOCATION (City, town, or county) <u>FAIR LAWN</u> (State) <u>N.J.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>WALTON, MD.</u>			
24a. REC'D BY REGISTRAR <u>JUL 29 1957</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Thomas</u>			

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

107 29 1957

RECEIVED

07396

CERTIFICATE OF DEATH

Reg. Dist. No. 102

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Old.</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>New Smy</i>				c. LENGTH OF STAY IN 1b <i>45 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO New Smy</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>J</i>				d. STREET ADDRESS <i>J</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Shemond</i> First <i>Posey</i> Middle <i>Posey</i> Last				4. DATE OF DEATH Month <i>July</i> Day <i>20</i> Year <i>1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>7-20-57</i>	
9. AGE (In years, lost birthday, yrs.) <i>45</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Practitioner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Infant</i>		11. BIRTHPLACE (State or foreign country) <i>Old</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>				13. FATHER'S NAME <i>William A. Posey</i>			
14. MOTHER'S MAIDEN NAME <i>Ruth Irene Gatricle</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service) <i>—</i>			
16. SOCIAL SECURITY NO. <i>—</i>				17. INFORMANT <i>Wm A. Posey</i> Address <i>New Smy Old</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>776x</i> DUE TO <i>Practitioner (6 month Practitioner)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>						INTERVAL BETWEEN ONSET AND DEATH <i>45 min</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7/20</i> , 19 <i>57</i> , to <i>7/20</i> , 19 <i>57</i> that I last saw the deceased alive on <i>7/20</i> , 19 <i>57</i> , and that death occurred at <i>5:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Frank H. Susan</i> M.D.				ADDRESS (Street, city or town, state) <i>Indian Head Old</i> DATE SIGNED <i>7/20/57</i>			
PHYSICIAN'S NAME (Type) <i>Frank A. Susan M.D.</i>				<i>Old-gland</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>7-21-57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Old Hope Church</i>		22d. LOCATION (City, town, or county) (State) <i>Trums Old</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nave (Baby Buried by Father)</i> ADDRESS				24a. REC'D BY REGISTRAR <i>July 21</i>		24b. REGISTRAR'S SIGNATURE <i>cl v Thompson</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

101 25 1957

RECEIVED

07397

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>The</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Tompkinsville</i>		c. LENGTH OF STAY IN 1b <i>2 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Rural</i>		d. STREET ADDRESS <i>Rural Tompkinsville</i>	
3. NAME OF DECEASED (Type or print) <i>HERBERT</i> first <i>ERANVILLE</i> Middle <i>St Clair</i> Last		4. DATE OF DEATH <i>7</i> Month <i>30</i> Day <i>1957</i> Year	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-10-90</i>
9. AGE (In years at birth) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SHOE</i>	
11. BIRTHPLACE (State or foreign country) <i>St Marys Co MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Charles Henry St Clair</i>		14. MOTHER'S MAIDEN NAME <i>Frances Eleanor Herbert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>571-05-546</i>	
17. INFORMANT <i>Wife (Mrs) Tompkinsville Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gunshot wound of head</i> 976x DUE TO <i>Self inflicted</i> Conditions, if any, which gave rise to immediate cause (b) <i>Severe cerebral-vas artaio sclerosis</i> (a), stating the underlying cause last. <i>2-57</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>INTERNAL BETWEEN 7-30-57 AND DEATH 7-30-57</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Shot self c 12 gauge gun</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <i>8 30 a.m. 7-30 19 57</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State) <i>Tompkinsville Char Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E J Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E J. EDELEN</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <i>A</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-2-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Christ Church</i>
22d. LOCATION (City, town, or county) <i>Way Side</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert Mc Laplata</i>		ADDRESS <i>Md</i>	
24a. REC'D BY REGISTRAR <i>7/31/57</i>		24b. REGISTRAR'S SIGNATURE <i>Julia Hasey</i>	

MEDICAL CERTIFICATION

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FORMAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1-18-57
J. H. [unclear]
[unclear] [unclear]
[unclear] [unclear]

HEXBERT GRANVILLE & CLAIR
7-10-50
[unclear] [unclear]

SAIGMAN HANCOCK
21-10-54
[unclear] [unclear]

1-30-51
1-30-51
1-30-51
[unclear] [unclear]

2-1-51
J-30-51
[unclear] [unclear]

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The boxed copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07391

07398

CERTIFICATE OF DEATH

Reg. Dist. No. 106

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Potomac Hts.</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Heights</u>		TOWN <u>NO</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>MARGARET ORA Smith</u>				4. DATE OF DEATH (Month) <u>7</u> (Day) <u>4</u> (Year) <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-30-1889</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEVI TIPPY</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA STEIN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Harold Smith, Potomac Hts-Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>153X Carcinoma Sigmoid Colon</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Hemorrhage</u>						<u>4yr.</u>	
19a. DATE OF OPERATION <u>331X</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 5, 1956, to July 4, 1957, that I last saw the deceased alive on July 4, 1957, and that death occurred at 3:45 PM, from the causes and on the date stated above.							
SIGNATURE <u>Frank G. Quisenberry M.D.</u>		ADDRESS (Street, city, town, state) <u>Indian Head Md.</u>		DATE SIGNED <u>7-4-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>	DATE THEREOF <u>7-5-57</u>	NAME OF CEMETERY OR CREMATORY <u>Lee Funeral Home</u>		LOCATION (City, town, or county) <u>Washington D.C.</u>		(State)	
24. REC'D BY REGISTRAR <u>Adley Price</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Smith</u>		ADDRESS <u>WALDORF, MD.</u>	
DATE <u>JUL 9 1957</u>							

CERTIFICATE OF DEATH

MADE IN THE STATE DEPARTMENT OF HEALTH - BALTIMORE 12

Reg. No. 100

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. AGENT OF DEATH

8. SEX OF DECEASED

9. AGE OF DECEASED

10. COLOR OF DECEASED

11. OCCUPATION OF DECEASED

12. EDUCATION OF DECEASED

13. MARITAL STATUS OF DECEASED

14. RELIGION OF DECEASED

15. PLACE OF BIRTH OF DECEASED

16. DATE OF BIRTH OF DECEASED

17. NAME OF DECEASED

18. NAME OF DECEASED

19. NAME OF DECEASED

20. NAME OF DECEASED

21. NAME OF DECEASED

22. NAME OF DECEASED

23. NAME OF DECEASED

24. NAME OF DECEASED

25. NAME OF DECEASED

26. NAME OF DECEASED

27. NAME OF DECEASED

28. NAME OF DECEASED

29. NAME OF DECEASED

30. NAME OF DECEASED

31. NAME OF DECEASED

32. NAME OF DECEASED

33. NAME OF DECEASED

34. NAME OF DECEASED

35. NAME OF DECEASED

36. NAME OF DECEASED

37. NAME OF DECEASED

38. NAME OF DECEASED

39. NAME OF DECEASED

40. NAME OF DECEASED

41. NAME OF DECEASED

42. NAME OF DECEASED

43. NAME OF DECEASED

44. NAME OF DECEASED

45. NAME OF DECEASED

46. NAME OF DECEASED

47. NAME OF DECEASED

48. NAME OF DECEASED

49. NAME OF DECEASED

50. NAME OF DECEASED

51. NAME OF DECEASED

52. NAME OF DECEASED

53. NAME OF DECEASED

54. NAME OF DECEASED

55. NAME OF DECEASED

56. NAME OF DECEASED

57. NAME OF DECEASED

58. NAME OF DECEASED

59. NAME OF DECEASED

60. NAME OF DECEASED

BUREAU V. S.

JUL 9 1957

RECEIVED

07399

CERTIFICATE OF DEATH

Reg. Dist. No. 101

1. PLACE OF DEATH o. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARBURY		c. LENGTH OF STAY IN 1b 10 MARBURY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) FANNIE L WASHINGTON		4. DATE OF DEATH JULY 19 1957	
5. SEX FEMALE	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 16, 1894
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Hudson		14. MOTHER'S MAIDEN NAME Sarah Irby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-285462	
17. INFORMANT Charles Washington - Marbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIOPULMONARY INSUFFICIENCY 174X DUE TO SARCOMA OF UTERUS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO GENERALIZED METASTASIS (c) 5 MOS		INTERVAL BETWEEN ONSET AND DEATH 2 WAS 5 MOS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X DIABETES MELLITUS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY: Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from FEB. 23, 1957 , to JULY 19, 1957 , that I last saw the deceased alive on JULY 3rd, 1957 , and that death occurred at 4:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Chen		ADDRESS (Street, city or town, state) DATE SIGNED Accokeek, Md. 7-19-57	
PHYSICIAN'S NAME (Type) PAUL CHEN		Accokeek, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Mt. Hope Cemetery	July 22, 1957	Mt. Hope Cemetery	Mt. Hope, Charles MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Johnson and Tankins		ADDRESS 4804 Georgia Ave.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE 23 1957 Mary Southernland	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
Clerical		High School		Married		Catholic		White		White		Brown		Blue	
Cause of Death		Immediate Cause		Underlying Cause		Manner of Death		Place of Death		Date of Death		Time of Death		Signature of Physician	
Acute Myocardial Infarction		Coronary Artery Disease		Hypertension		Natural		Home		JUL 23 1968		10:15 PM		J. Edgar Hoover	
Attending Physician		Medical Examiner		Coroner		Registrar		Burial Place		Date of Burial		Time of Burial		Signature of Burial Officer	
J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover		J. Edgar Hoover	

BUREAU V. S.

JUL 24 1967

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07400 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07394

Reg. Dist. No. 105

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CHARLES</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newburg</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWBURG</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GUY</u> Middle <u>WASHINGTON</u> Last <u>WASHINGTON</u>				4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1957</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-85</u>			
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>2</u>		IF UNDER 24 HRS. Hours <u>19</u> Min. <u>57</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Henry Washington</u>				14. MOTHER'S MAIDEN NAME <u>Mary</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>9</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Delila Chase (daughter)</u>		Address <u>444 E St SE, DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of Head</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Self inflicted 12 gauge</u> DUE TO (c) <u>Shot gun blast</u>								INTERVAL BETWEEN ONSET AND DEATH <u>7-16-57</u> <u>7-16-57</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> o. m. <u>7-16</u> p. m. <u>1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Newburg Char MD.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>E. J. Edelen</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>E. J. EDELEN</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9-20-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shilo Methodist Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Shilo MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>				ADDRESS <u>WALDORF MD.</u>		24a. REC'D BY REGISTRAR <u>DATE 22 1957</u>			
				24b. REGISTRAR'S SIGNATURE <u>M. L. Monroy</u>					

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JUL 22 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG216 7-22-57 et

07401

CERTIFICATE OF DEATH

07395

Reg. Dist. No.

106

1. PLACE OF DEATH a. COUNTY Charles MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bryans Road				c. LENGTH OF STAY IN lb 18 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Bryans Road			
3. NAME OF DECEASED (Type or print) Thomas Muschette Wood First Middle Last				4. DATE OF DEATH July 8 1957 Month Day Year			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26. 1881 1879	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY U.S. Naval Powder Factory		11. BIRTHPLACE (State or foreign country) Newmarket, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Brooks Muschette				14. MOTHER'S MAIDEN NAME Mary Cecelia Wood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. — (If yes, give war or dates of service)		17. INFORMANT Annie A. Washington Address Bryans Road Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dichster Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 260X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.2 Chronic Myocarditis				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1955 to 7/8 , 19 57 that I last saw the deceased alive on 7/8/57 , 19 57 , and that death occurred at 10:45 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank A. Susan M.D.				ADDRESS (Street, city or town, state) Indian Head, Md. DATE SIGNED 7/8/57			
PHYSICIAN'S NAME (Type) Frank A. Susan M.D.				Indian Head, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		July 12, 1957		St. Josephs		Pomfret Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Huntt Funeral Home, Waldorf, Md. ADDRESS				24a. REC'D BY REGISTRAR July 15 1957 24b. REGISTRAR'S SIGNATURE Odey Price			

BUREAU V. 3

JUL 15 1957

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